for a consideration of isomerism in its various forms may aid the further correlation of chemical structure with physiological action, and therefore give a more fundamental conception of drug action. This, it may be hoped, will materially assist in making therapeutics more rational and scientific.

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Proctology

THE treatment of hemorrhoids as indicated in current literature presents little novelty. On the whole, the prevailing opinion is that prolapsing and prolapsed hemorrhoids should be surgically removed, while others giving symptoms (mainly bleeding) may be treated with injections. The subject is fully elaborated in a recent book by J. F. Montague.[1] For injection he prefers, as does the writer, a 20 per cent solution of phenol in glycerine using 3-5 minims for each hemorrhoid and injecting one or two hemorrhoids at a time. Others use a 5 per cent solution of urea and quinin hydrochloride and others again 95 per cent alcohol. The hemorrhoidal masses should be made to tumefy themselves within the rim of a Kelly's proctoscope assisted by the patient endeavoring to extrude them. Each is then sharply punctured by a hypodermic needle carrying the fibrosing fluid and the necessary amount injected. There is no pain unless the fluid is injected beneath the anal mucosa, when it may be very severe. Bleeding always may be stopped by this method and mild prolapse at stool prevented. On an average four injections into each hemorrhoid will suffice to bring about shrinkage. There is no interruption in the patient's activities.

Pennington[2] insists on his "open" operation. A small incision is made through the mucous membrane over the everted hemorrhoid, the "varicosity protruded" and "radically removed." This method, however, does not provide for the obviously redundant mucous membrane which has become part of the prolapsing varicose mass. Apart from Pennington's method, the ligature and excision method appears that most universally accepted. The Saint Mark's Hospital, London, plan is, without divulging the sphincter, to seize each hemorrhoid, draw it downward and to incise at the ano-cutaneous margin upward for half an inch or so. The incision is in the cellular tissue and separates the mucous membrane with varicose veins internally from the sphincter externally. Braided silk is tied tightly around the upmost limit of the separated hemorrhoid, which is then cut off beyond the ligature. The ligatures slough off in a week's time. The operation takes ten minutes. There is little bleeding and the wounds are not sewn up.

New statistics are available on the occurrence of cancer in the colon. Patterson and Brown[3] give 91 cases in the pelvic colon and 22 and 19 in the cecum and splenic flexure respectively in a series of 171 cases. These exclude any that might possibly be thought to arise in the rectum. Walker[4] states that 60 per cent occur in the rectum and 20 per cent in the iliac and pelvic colon. A. H. Burgess[5] in 485 cases gives 46.5 per cent as occurring in the rectum and 29.4 per cent in the sigmoid colon. Seventy-five per cent of these were too extensive for radical operation, a tacit criticism of those who first see patients with colonic symptoms. In this large series 35.6 per cent were associated with acute obstruction and of these 86.7 per cent occurred in the left half of the colon. Thus "there is a 6.5 to 1 chance of a malignant growth that has caused obstruction being on the left side." The fact that more than one-third of cancers of the large bowel are associated with acute obstruction demonstrates that both in operable and inoperable cases procrastination is not permissible before an opening, either palliative or in the course of radical surgery, is made to drain the bowel above the diseased area.

M. S. WOOLF.

1. Modern Treatment of Hemorrhoids by J. F. Montague. J. B. Lippincott, 1926.

2. Hemorrhoids, J. Rawson Pennington. J. A. M. A., December 18, 1926.

3. Cancer of the Colon, Patterson and Brown. Edin. Med. J., 1926, 33, 10.

4. Cancer of the Colon, Walker. Glasgow, Med. J., February, 1926.

5. Cancer of the Gastrointestinal Tract. A. H. Burgess, B. M. J., January 1, 1927.

Radiology

RADIATION Therapy in Its Relation to the Cancer Problem—A well-known authority is quoted to the effect that about 10 per cent of cancer patients, excepting the skin varieties, are curable by surgery, which means that in communities where competent surgical aid is available, 10 per cent of all classes of cancer (skin cancer excepted) recover if submitted to surgery, and may be considered surgical cures. On the other hand, a classification of radiation therapy in the same analysis appears equally favorable, if not more so. Most of the radiation therapy results, on which we have reasonably reliable data, cover carcinoma of the breast and uterus. If we limit our surgical cures to these two fields the percentage would unquestionably increase, perhaps, to 15 or 20 per cent. Similarly if we limit our investigations on radiation cures to the same classification, and take statistics of such cases as are treated in acceptable institutions by x-rays and radium, the clinical cures vary from 20 to 25 per cent. In some outstanding clinics where exceptional skill in the use of radiation therapy is manifested, clinical cures run up to 30 per cent. Of course the favorable increase here is undoubtedly largely influenced by the preponderance of uterine cases over those of the breast.

Whether or not an intelligent cooperation between surgeons and radiologists, and the combined use of these agents in the field under discussion will materially increase the clinical cures, must be, in the light of experience, answered in the affirmative.

It appears that surgery, from a mechanical standpoint at least, has well-nigh reached perfection and it is difficult to visualize any drastic change from present technique either in application or results from this agency alone.

Radiation therapy, however, is still open to further study and development sufficient to warrant